MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address The San Antonio Orthopaedic Surgery Center PO Box 34533 San Antonio TX 78265-4533	MDR Tracking No.: M4-04-0288-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX: 29 San Antonio ISD / Dean Pappas & Assoc.	Date of Injury: Employer's Name: San Antonio ISD Insurance Carrier's No.: 98000204

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2/11/03		29827, 29824, 29826, 99070	$14,754.17	Same F&R range pd.
			IC Paid:	($8,327.80)
			Add'l Reimb.Due:	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The carrier paid the provider based on the "M" Code of "no MAR". Under section 413.011 and 133.304, the carrier is obligated to pay fair and reasonable compensation. The documentation provided demonstrated the quality of care was delivered to the patient. Cost control has been achieved through our application of a reimbursement for services rendered. Our usual and customary fees were determined using the Ingenix database, which is a nationally accepted database and makes our fees fair and reasonable. The respondent (carrier) has failed to show that their payment is fair and reasonable.

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent noted on the 'Table of Disputed Services,' "Bill was paid based on what similar facilities charge for same procedures +30% markup."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

Claimant underwent: 'Shoulder Arthroscopy with rotator cuff repair, distal claviculectomy including distal articular surface and decompression of subacromial space with partial acromioplasty with or without coracoacromial release'. An operative report was not attached to the medical dispute, and documentation was requested on 3/22/04 and documentation has not been received from the request.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market

payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 192.6% to 256.3% of Medicare for year 2003). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, the original reimbursement on these services is within the medium to high end of the Ingenix range. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Findings and Decision by:

		7 / 25 / 05
Authorized Signature	Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on ___19_____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____